PRINTED: 06/27/2011
FORM APPROVED
OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0	0391	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	COMPLETED	
		155753	B. WING		05/31/2011		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER							
HAMPTON OAKS HEALTH CAMPUS			966 N WILSON RD SCOTTSBURG, IN47170				
	_			100010, 1147 170			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT			
PREFIX	1	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	PRIATE	ION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0000							
		or a Post Survey Re-visit	F0000			i	
	to the Recertific	cation and State Licensure				i	
	Survey complete	ed on April 8, 2011.				i	
		•					
	Survey Date: M	av 31, 2011				i	
		ay 51, 2011					
	Eggility number	- 004002					
	Facility number: 004902					i	
	Provider number: 155753					i	
	AIM number: 200813130						
	Survey team:						
	Avona Connell, RN TC						
	Donna Groan, RN						
	Dorothy Navetta, RN					i	
	Gloria Reisert, N						
	Gioria Reisert, r	VIS W					
	C						
	Census bed type	.				i	
	SNF: 18					i	
	SNF/NF: 46						
	Residential: 21						
	Total: 85						
	Census payor ty	rpe:				i	
	Medicare: 18	r ···					
	Medicaid: 36						
	Other: 31					i	
	Total: 85						
	Sample: 09						
	Residential sam	ple: 04					
		r					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SSLP12

Facility ID:

004902

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BIII	I DING	00	COMPI	LETED	
		155753	A. BUILDING B. WING			05/31/2011		
NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN47170				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO			COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)		DATE		
		es also reflect State						
	Findings cited ir	accordance with 410						
	IAC 16.2.							
	Quality review of Cathy Emswiller	•						

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Event ID:

SSLP12

Facility ID:

004902

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
155753		155753	B. WING		05/31/2011		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER						
HAMPTC	ON OAKS HEALTH (CAMPUS	966 N WILSON RD SCOTTSBURG, IN47170				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0225 SS=D	have been found or mistreating residence had a finding nurse aide registry mistreatment of residence of their property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including ir and misappropriat reported immediate the facility and to owith State law through the service of the service	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an awould indicate unfitness for aide or other facility staff to de registry or licensing on the interest of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification					
	agency). The facility must halleged violations and must prevent the investigation is The results of all in reported to the addrepresentative and accordance with State survey and oworking days of the violation is verified action must be tak Based on record the facility failed.	ave evidence that all are thoroughly investigated, further potential abuse while in progress. Investigations must be ministrator or his designated at to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective	F0225	Resident #36 missing pai patch investigation was completed to include investig with CNAs.2. All current	*************************************		
		nvestigated for 1 of 3 ed for misappropriation		employees were interviewed regarding the patch investiga			

004902

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		155753	- 1	A. BUILDING		05/31/2	011
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	VILSON RD		
HAMPTON OAKS HEALTH CAMPUS				1	SBURG, IN47170		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)	+	TAG	,	DATE	
	1	pain patch in a sample of			5 residents currently have pa patches and continue to be		
	9. (Resident #3	6)			checked for placement every	/ shift	
					by licensed staff. Tegaderm and/or tape is utilized to reinforce		
	Findings include	:					
					the patch to prevent		
	1 The clinical r	record for Resident #36			dislodgement. 3. The ED a		
					DHS were re-educated regar	• • •	
	was reviewed on 5/31/11 at 10:55 a.m. The resident's diagnoses included, but			the expectation of for thor			
	1	-			investigating in compliance vectors this regulation to include	VILTI	
		to congestive heart			interviewing CNAs. A follow-	-un	
	failure and hypertension. Signed and				meeting on 6/9/11 was held		
	1	s Order for May 2011			the local police investigator i		
	included, but were not limited to: "Fentanyl (narcotic pain medication) 25mcg (micro grams)/hr (hour) TD (transdermal) patch apply 1 patch topically every 72 hrs for pain"			attempt to identify a perpetrator.			
					All Nursing staff were re-edu		
					to review concerns of missin		
					and/or dislodged pain patche		
					and the importance of reporting immediately when identified as		
					missing.4. Home Office Supp		
	Nurgala Notas in	dicated 5/14/11 10:30			staff will review any future	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
					investigations conducted by	the	
	1	n not in place New one			ED and/or DHS to ensure		
	placed. No c/o (complaints of) pain no				thorough investigation, to inc		
	facial grimacing	no signs of pain"			interviewing pertinent staff.		
					addition, these investigations be checked during the month		
	Review of the M	lay 2011 Medication			campus visit conducted by the	-	
	Administration Record indicated the				Home Office Support. These		
	Fentanyl patch h	and been applied on			audits will continue a minimu		
	5/13/11 "upon arising." During interview on 5/31/11 at 10:40 a.m., the Administrator indicated Resident #36 was missing the pain patch as it could not be found anywhere. She indicated that they suspected a Qualified				6 months. Results will be		
					reviewed in monthly QA mee		
					and if 100% compliance is no	ot	
					reached for 3 consecutive		
					months, monthly audits will continue until this threshold i	, l	
					met.		
	Medication Aide	e (QMA) who was on duty					
	at the time. One patch could not be found						

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DIVILIDING 00		00	COMPLETED	
155753		155753	A. BUILDING B. WING			 05/31/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹			VILSON RD		
LIAMOTO	NI OAKO UEALTU.	CAMPLIC					
HAMPIC	N OAKS HEALTH	CAMPUS	SCOTTSBURG, IN47170				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on the resident o	r clothing. Another					
	resident's missin	g patch was found in their					
	clothing.	8 F					
	Clouming.						
	On 5/21/11 of 1.4	00 n m in interview with					
		08 p.m., in interview with					
	the Administrator, she indicated the						
	Certified Nursing Assistants (CNA) were						
	not interviewed as part of the						
	investigation into the allegation of 2 (two)						
	missing pain patches. She indicated "we						
	didn't want to tip anyone off." We asked						
	1						
		y suspected any CNA.					
	We came in, looked @ the schedule and						
	didn't want to tip everyone. I wanted to						
	catch them. Documentation was lacking						
	of a thorough investigation including the						
	CNA's who had contact with the						
	residents.						
	3.1-28(d)						
R0000							
			R(0000			

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